ANNUAL REPORT

Assessment and Placement Service of the Hamilton Wentworth District Health Council

APS

1977

SIXTH ANNUAL REPORT
OF THE
ASSESSMENT AND PLACEMENT SERVICE
OF THE
HAMILTON WENTWORTH DISTRICT HEALTH COUNCIL

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1. Resigned September 1977
2. Appointed during 1977

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HISTORICAL BACKGROUND

The A.P.S. was established by the Hamilton District Health Council in 1971 on the advice of the then newly formed Extended Care Committee. The project was funded in April of that year by the Ontario Ministry of Health and commenced operation in September 1971.

One of the concerns of the Health Council has been the promotion of optimal utilization of the services for the disabled and chronically ill. The Extended Care Committee was formed to study the needs of this group and the services available. The result of their discussions was the recommendation that a coordinating body be formed to obtain the medical, social and nursing evaluations of the disabled and chronically ill and make recommendations of the appropriate programs or levels of care for the development of the individual's assets and potential.

The Health Council appointed a medical consultant and two members of the health professions to provide the coordinating evaluation function; a part-time administrator and secretarial staff; and a data analyst to maintain statistics for the evaluation of the services's efficacy and the provision of an information base for future planning in the health needs of the disabled.

ASSESSMENT FORM

Prior to commencement of operation an Assessment tool was developed to provide the necessary information for appropriate recommendation. Broadly, this information falls into three categories:

(a) demographic (age, sex, marital status, next-of-kin, education, employment and cultural background, present location and level of income)

(b) medical (diagnosis, prognosis, treatment, level of cognitive function, emotional status)

(c) functional capacity (degree of ability to walk, talk, see, hear, comprehend, dress, bathe, undertake personal care and household care).

The demographic and functional capacity data is provided by a social worker-nurse team for the hospitalized applicant and by the Public Health, Victorian Order or St. Elizabeth Nurse for those applicants at home. The medical information is provided by the applicant's personal physician.

RECOMMENDATIONS

Recommendations are made on the basis of the information provided by the Health Care team with additional input as indicated and with an intimate knowledge of the available facilities and programs.

Recommendations include appropriate level of care, and/or programs of rehabilitation or recreation, and programs whereby the disabled person may be assisted toward a meaningful role in society.

REFERRAL PROCESS

Referrals are made by health professionals in the community or health care institutions and/or members of the community, and may be as simple as a telephone call asking for the process to be set in motion.

DEFINITIONS:

Assessment	- the evaluation of the needs, capabilities, and assets of the applicants from the information supplied by physicians, nursing and social services and other health professionals.
Placement	- the identification and recommendation of the most suitable program(s) to meet the applicant's needs and develop his/her potential capabilities, and facilitation of the movement of the applicant to the site of the program(s) or the movement of the program(s) to the individual.
Referral Form	- the A.P.S. designed form used by the health professionals to provide demographic, medical, environmental and cultural background information on the applicant. Revised January 1976.

MEDICAL CONSULTANT'S REPORT

- J.R.D. Bayne, M.D., F.R.C.P. (C)., F.A.C.P. -

THE PROFESSIONAL ROLE OF THE ASSESSMENT & PLACEMENT SERVICE

The Assessment & Placement service provides professional advice to the referring physician and associated health professionals in finding services that can respond to the needs of chronically disabled persons. On the basis of information supplied through the assessment form, the A.P.S. Counsellor gains a picture of the person and his needs, and recommends appropriate action in order to clarify treatment requirements, improve the person's function or provide on-going support and care.

Two problem areas were pointed out in the Annual Report for 1976; difficulties health professionals have in assessing specific needs and responding to them, and difficulties that exist in the provision of appropriate services and programs for certain groups of people with special problems. In general the assessment of needs has been found to be reliable, and the A.P.S. Counsellor is able to recommend the required services or action. The great majority have been reported as satisfactory on follow-up.[1] The problems arise with a smaller group in whom the usual diagnostic procedures are not adequate to identify the picture fully enough, or such procedures are not thought of or considered. This is especially liable to happen when an old person has one or more already identified diseases. All subsequent losses in function are then apt to be attributed to these causes. Sometimes "senility" or "cerebral arteriosclerosis" is given as the explanatory diagnosis to account for a variety of physical and mental impairments which may well have other causes. Any loss of function, even in very old people and especially if sudden in onset requires an explanation, and may be due to treatable physical or mental pathology or simply due to altered social arrangements and relationships. Although such problems of insufficient investigation are not of great frequency there are enough to warrant further action.

A proposal was therefore developed for the Hamilton-Wentworth District Health Council and for the Health Sciences faculties of McMaster University and Mohawk College to establish a Geriatric Assessment Service and a Unit (Geriatric Medicine and Psychiatry) in one of the general hospitals. This Unit will relate to and complement the existing geriatric services available in St. Peter's Geriatric Hospital and Day Therapy Centre, Nursing Homes, Homes for the Aged and lodging houses, short-term and long-term Home Care programs, Meals-on-Wheels and a variety of recreation programs. The Unit will be based in a general hospital, in order that it can provide a full diagnostic evaluation, functional assessment and management advice, in addition to consultations in geriatric

medicine and geriatric psychiatry. It will provide consultation to persons at home or in institutions, or arrange admission to Day Hospital or for a short stay as an in-patient. Planning for this Unit is now in the final stages. It should be noted that the purpose is not to duplicate the already extensive diagnostic and treatment services available to older people, but to supply particular expertise and facilities for special problems to improve diagnosis and management and to enable practising professionals to increase their skills and understanding and the quality of their practises.

The other problem area of difficulty in the provision of appropriate services and program skill continues. In addition to there being a waiting list for admission to all long stay accommodation, there are groups for whom no appropriate facility exists. One such group includes those persons who are forgetful and impaired in judgement but who are physically relatively well and ambulant. A review was made of the A.P.S. records for 1975 and 1976 and 205 persons with these characteristics were identified. The review enabled their care needs to be analysed and a study to be made of the program which was recommended and that which was obtained. Two reports[2,3] were produced for publication. The study showed that the needs could be clearly identified and that a variety of placements were made ranging from remaining at home to several kinds of residential care. These placements related more closely to the physical care needs than to any special psychological management requirements, and pointed to the lack of special facilities for the mentally impaired elderly.

Another aspect of the difficulty in finding appropriate long stay residential care is the lack of facilities and programs for younger persons with severe disabilities. Many young persons are cared for at home by devoted parents, spouses or relatives, but when care becomes too onerous or if life in a private house is too limited, there is no appropriate facility to provide the level of care needed and a program of meaningful activities and social contacts. Too often placement in an institution that cares for the elderly is the only possible action. . This recommendation is only made after careful consideration and search for alternatives. A praiseworthy initiative has been shown by citizen groups who have created special homes for the handicapped in which they can receive care and companionship. However there is no coordinated plan to make such facilities generally available in the province, and therefore no assurance can be given to an individual or family that relief or remedial action will be coming in the future.

The ready availability of drugs, and the tendency to their excessive use has been receiving attention in recent years. A study was carried out using data obtained through A.P.S. with assistance from the community and public health nurses to evaluate the appropriateness of the use of psychoactive drugs for all persons age 65 and over referred to A.P.S. The report is to be published,[4] but in brief it showed that approximately 25% of the elderly were prescribed at

least one psychoactive drug, and that although no person was prescribed more than three psychoactive drugs simultaneously, 25% who were receiving such drugs received more than one. There is a danger that the person may confuse these drugs and take them inappropriately, and indeed the study showed that two-thirds of the persons referred were mentally or physically unable to administer their own medications. Although these drugs should only be prescribed for specific purposes, the study showed a lack of relationship of symptoms or diagnoses to the drugs prescribed.

Those studies show up the deficiencies in the health care system but provide some precision of information so that appropriate action can be taken. The purpose of A.P.S. is not only to assist in enabling disabled persons to find appropriate services, but to assist in improving the quality of those services and to provide health professionals with information on using services and in planning improvements.

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ADMINISTRATOR'S REPORT

Joyce Caygill

Once again we have seen our active caseload increase as it has done steadily since 1971. In 1972 our active cases numbered less than 200 at any given time. In 1977 there were in excess of 650 active cases at any given time. It should be noted that this increase in activity has been effected without a corresponding increase in staff. Use of computerized waiting lists and more efficient mechanisms of "paper-flow" through the office have allowed us to use professional and secretarial staff time to better advantage and still allow opportunities for staff to maintain face-to-face contact with hospital and facility representatives on a regular, weekly basis.

During the year we were able to assist Dr. Lowell Gerson et al with studies for the Non-Medical Use of Drugs Directorate; Dr. Michael Ashong with several studies related to the use by the elderly of psychotropic drugs; and to produce articles of our own.

We have acted as resource persons to study groups and committees involved with the care of the elderly and disabled both locally and provincially and as an educational resource to undergraduate and postgraduate health professionals.

The year end data gave us material of considerable interest to those involved in planning. Only a very small portion of our data is reprinted in this report.

This 1977 Annual Report covers the period January 1 to December 31, 1977. Future reports will cover the period April 1 to March 31 in order to comply with the recent Ministry of Health change in fiscal year. Data is available for the three month period January 1 - March 31, 1978 but is not reported here.

ADVISORY SERVICE

REFERRALS

In 1977 we were involved with 2763 cases, 700 of which were referred prior to January 1, 1977 but not placed. 2069 cases were closed during the period January 1, and December 31, 1977 and provide the data used in this report. Local hospitals referred 982 of these cases, families referred 354 directly to our service, visiting nurses (Public Health, V.O.N. etc.) accounted for another 261, physicians referred 185 and

a further 278 referrals came from sources such as friends, religious and financial advisors, nursing homes, lodging houses, and facilities outside the region, province or country. Missing data: 9.

Once again generalized ischemic cerebrovascular disease heads our list of most frequent diagnoses. Fracture of the neck of the femur placed twelfth as in 1976 (113).

WAITING LISTS

As in previous years the waiting lists increased in 1977 with an average of 617 persons awaiting placement in a program at any time during the year. Peak month again was December with 663 and lowest month again was July with 571. In 1976 highest month was December with 594 and lowest July with 468. This is the first occasion that we have seen similarity in the waiting list patterns.

1974	High - September,	Low - January
1975	- July	- March
1976	- December	- July
1977	- December	- July

Sample month: November 1977. Location of persons awaiting admission to a program were as follows.

In acute treatment hospitals awaiting admission to:

Nursing Homes	157
Chronic Hospitals	88
Homes for the Aged	40
Rehabilitation Units	3
Services in the Community	26
	314

At home (or in other facilities) awaiting admission to:

Nursing Homes	103
Chronic Hospitals	30
Homes for the Aged	109
Rehabilitation Units	7
Services in the Community	50
	299

(see also Table on p.)

TOTAL 613

PLACEMENT

1572 placements were made in 1977, 1234 of these were first placement, 275 second placement and 63 were third placement. Several persons required more than three placements (15). (Some clients require more than one placement in a program before the final setting is reached. i.e. rehabilitation prior to nursing home placement) 956 of these were considered to be "final" placement. 389 persons died before placement, 101 within 90 days of placement and 30 of these were within 14 days of placement. 491 persons refused placement. 694 cases were still active on December 31, 1977.

CLIENT SATISFACTION

One month following placement letters are sent enquiring whether or not placement has proved satisfactory. These letters are sent to the client whenever possible, to the family if the client is unable to respond personally, or to the receiving facility if client is unable to respond and is without family. In 1977 we received 849 replies from patient or family, 802 (94%) stated placement was satisfactory, 46 felt placement was unsatisfactory. We also received 846 replies to our letters to facilities of which 833 (98%) expressed satisfaction, 13 did not. In each of the unsatisfactory responses we endeavour to determine the cause of dissatisfaction and attempt to make appropriate arrangements.

IDENTIFICATION OF NEEDS WITHIN THE COMMUNITY

In our 1976 Annual Report we commented upon the difficulty in placing the "young" client at the nursing home level of care. These persons require on-going nursing and personal care and also a vigorous program of activities to ensure a feeling of community, self worth and self respect. They are entitled to see themselves (and be seen) as worthwhile, useful members of society. All too often they are lost to society's view in groupings of elderly, often confused, persons. Clinical and administrative staff of many nursing homes have expressed great concern for those who require the type of care described. Frequently a nursing home will refuse admission because of this concern. One Hamilton area nursing home owner is considering the feasibility of developing a program suited to the needs of these "young" people, never-the-less, the situation as reported in 1976 has not changed.

Similarly, the situation reported in 1976 with regard to the confused, ambulant elderly has not changed. It will be seen from the list of ten most frequently recorded diagnoses and the tables on memory and judgement that the incidence of impairment of cerebral function is very high. At present, the most appropriate facilities for the care of these persons are the Homes for the Aged, which operate under the regulations set out in the Ontario Ministry of Community and Social Services "Homes for the Aged and Rest Homes Act". Nursing Homes accept a good number of these confused persons although

the physical design and location of their facilities may not always be suitable. Nursing Homes are governed by the Ontario Ministry of Health "Nursing Homes Act". In view of the greater numbers of confused persons requiring long term care it may be timely for consideration to be given to development of non-traditional facilities which cater solely to the care of the confused person. Not only could the design of the facility be more suitable for those who are physically able to move about freely and cause difficulty in care because they wander away from their residence, but programs could be designed specifically for their needs.

Now, more than ever before, members of the community are aware of the problems facing us in the care of our disabled and elderly. Groups of concerned individuals are forming to discuss possible solutions. As you have read in our Consultant's Report, a Geriatric Assessment Unit is in the final planning stages which will provide additional diagnostic and treatment facilities, however, this Unit will not provide long term residential care. To date no definite proposals have been made for additional residential care of the confused, ambulant elderly person.

LOCATION AT TIME OF REFERRAL

Location		
Joseph Brant Hospital	125	
Chedoke Hospital	96	
Henderson Hospital	235	
St. Joseph's Hospital	251	965
Hamilton General Hospital	190	
*M.U.M.C. (Hospital)	68	
**H-W.B. Community	823	
Other H-W.B. facilities	162	
Facilities other than H-W.B. areas	47	
Community other than H-W.B.	37	
Outside Ontario	6	
Missing data	29	

*M.U.M.C. = McMaster University Medical Centre

**H-W.B. = Hamilton-Wentworth Region and Burlington

N = 2069

LOCATION OF PLACEMENT

Location	H-W.B.*	Outside H-W.B.	Outside Ontario	
Chronic Hospitals	228	12		
Nursing Homes	344	77		
Homes for the Aged	93	24		
Rehabilitation	39	--		
Ham. Psych. Hospital	25	--		
Homes for Spec. Care	2	--		
Other facilities	2	--		
Private residence	158	8		
Lodging house	100	2		
Day Care Centre	61	--		
Home Care Program	141	--		
Other	2	--		
Active Treatment Hospitals	261 ---	3	5	
TOTALS	1456	126	5	1587

*H-W.B. = Hamilton-Wentworth Region and Burlington

TEN MOST FREQUENTLY LISTED DIAGNOSES

Number of Diagnoses recorded 5421

Number of different Diagnoses recorded 350

Average number of Diagnoses per referral 2.62

Diagnosis	Absolute Frequency	Percentage of 5421
1 Generalized ischemic cerebrovascular disease	302	5.6
2 Cerebral thrombosis	293	5.4
3 Chronic ischemic heart disease	258	4.7
4 Osteoarthritis and allied conditions	256	4.7
5 Essential benign hypertension	232	4.3
6 Diabetes mellitus	220	4.1
7 Arteriosclerosis	217	4.0
8 Senile and presenile dementia	208	3.8
9 Symptomatic heart disease	181	3.3
10 Psychosis associated with other cerebral condition	171	3.1
	2338	43.0

MEMORY - recorded by Attending Physician on Assessment Form, Section B., page 2, 1977

1	Normal	371
2	Brief periods of forgetfulness	477
3	Brief periods of confusion	500
4	Periods of marked confusion	406
5	No recall	115
	Missing information	200
	TOTAL	2069

JUDGEMENT

1	Normal	224
2	Adequate for personal safety	464
3	Limited	656
4	Gross impairment - unrealistic	304
5	Unable to make any judgement	232
	Missing information	189
	TOTAL	2069

FOUR YEAR COMPARISON OF WAITING LISTS FOR THE MONTH OF NOVEMBER

In acute treatment hospitals awaiting placement

Facility required	1974	1975	1976	1977
Nursing Homes	75	65	101	157
Chronic Hospitals	44	67	86	88
Homes for the Aged	15	16	39	40
Rehabilitation Units		15	6	3
Services in the Community		14	19	16
Other				10
Total in hospital	134	177	251	314

In the community awaiting placement

Facility required	1974	1975	1976	1977
Nursing Homes	91	66	130	108
Chronic Hospitals	15	25	51	30
Homes for the Aged	68	58	60	109
Rehabilitation Units	6	3	3	2
Services in the Community	38	68	4	23
Other				27
Total in community	218	220	328	299
Total awaiting placement	352	397	579	613

OPERATING EXPENSES

year end -	*Dec 31, 77	Dec 31, 76
Salaries	120,525	116,854
Employee benefits	12,689	10,854
Office Space	11,220	11,220
Advertising	46	136
Insurance	271	250
Business Machines	1,227	1,759
Postage	1,337	965
Office supplies	2,761	2,408
Telephone	2,817	2,081
Travel	1,364	1,231
Data processing	5,454	4,074
Staff training	175	71
Audit	**500	500
Other	71	88
	160,457	152,224

* these figures prior to audit due to change in fiscal year

** estimated audit fee

TYPES OF CARE

(extract: Patient Care Classification by Types of Care, Ontario Ministry of Health publication #75-2222 8/75, pp3-4)

TYPE 1 (RESIDENTIAL CARE)

Care required by a person who is ambulant and/or independently mobile, who has decreased physical and/or mental faculties, and who requires primarily supervision and/or assistance with activities of daily living and provision for meeting psycho-social needs through social and recreational services. The period of time during which care is required is indeterminate and related to the individual condition.

TYPE 2 (EXTENDED HEALTH CARE)

Care required by a person with a relatively stabilized (physical or mental) chronic disease or functional disability, who having reached the apparent limit of his recovery, is not likely to change in the near future, who has relatively little need for the diagnostic and therapeutic services of a hospital but who requires availability of personal care on a continuing 24 hour basis, with medical and professional nursing supervision and provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years.

TYPE 3 (CHRONIC)

Care required by a person who is chronically ill and/or has a functional disability (physical or mental) whose acute phase of illness is over, whose vital processes may or may not be stable, whose potential for rehabilitation may be limited, and who requires a range of therapeutic services, medical management and skilled nursing care plus provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years.

TYPE 4 (SPECIAL REHABILITATIVE CARE)

Care required by a person with relatively stable disability such as congenital defect, post-traumatic deficits of the disabling sequelae of disease, which is unlikely to be resolved through convalescence or the normal healing process, who requires a specialized rehabilitative program to restore or improve functional ability. Adaptation to this impairment is an important part of the rehabilitation process. Emotional problems may be present and may require psychiatric treatment along with physical restoration. The intensity and duration of this TYPE OF CARE is dependent on the nature of the disability and the patient's progress, but maximum benefits usually can be expected within a period of several months.

TYPE 5 (ACUTE)

Care required by a person:

a) who presents a need for investigation, diagnosis or for definition of treatment requirements for a known, an unknown, or potentially serious condition; and/or

b) who is critically, acutely or seriously ill (regardless of diagnosis) and whose vital processes may be in a precarious or unstable state; and/or

c) who is in the immediate recovery phase or who is convalescing following an accident, illness or injury and who requires a planned and controlled therapeutic and educational program of comparatively short duration.

TERMINOLOGY IN COMMON USE IN ONTARIO

TYPE 1 CARE

Where provided

Homes for the Aged
Charitable institutions
Nursing homes
Foster homes
Group homes
Boarding homes
Homes for special care (residential care)
Children's institutions
Homes for unmarried mothers

Terminology

Domiciliary care
Ambulant care
Normal care
Residential care
"Intermediate care" in nursing homes
Community (social) support programs
(mental)
- day care
- sheltered workshops
- supervised recreation

TYPE 2 CARE

Where provided

Homes for the Aged
Nursing homes
Homes for special care (nursing homes)
Children's institutions

Terminology

Extended health care
Extended care
Homes for special care programs

TYPE 3 CARE

Where provided

Chronic hospitals
Chronic care units in general hospitals
Nursing homes approved for chronic care
Geriatric units in psychiatric hospitals
Special facilities (schedule II) for mentally retarded with physical handicap
Children's institutions

Terminology

Chronic care
Care of the chronically ill
Chronic hospital care
Psycho-geriatric units (psychiatric hospital)

TYPE 4 CARE

Where provided

Regional rehabilitation centres

Terminology

Special rehabilitation care
Rehabilitation

TYPE 5 CARE

Where provided

Public hospitals
Private hospitals
(G.H.P.U.) psychiatric units of general hospitals
Provincial psychiatric hospitals
Private psychiatric hospitals
Community psychiatric hospitals
Children's mental health centres

Terminology

Acute care
Active treatment
Psychiatric care (short and medium term)

ACKNOWLEDGEMENTS

We continue to enjoy the support and cooperation of the providers of health care in this area, and of McMaster University Computation Services Unit. We gratefully acknowledge their contribution to the continued operation of our service.

NOTES

Data was accessed using the Statistical Package for the Social Sciences (SPSS) software package on the CDC 6400 of McMaster University

Codes include:

Diagnosis	ICDA - 8 (International Classification of Diseases adapted for American use)
Medication	Non-medical use of Drug Study coding system (L. Gerson et al)
Location by facility	Ministry of Health Ministry Information System Division Data Development & Evaluation Branch Master Numbering System, 1976
Location by area	Ontario Postal Region Code
Physician	Medical Directory of the College of Physicians and Surgeons of Ontario

Mailing address for the Assessment & Placement Service:
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